Compensation and Billing

Before being reimbursed by Every Woman Matters (EWM), participating healthcare providers agree to provide reports of findings and recommendations which are necessary to compile cancer surveillance data and reports to the funder, the Centers for Disease Control and Prevention. Because collecting this public health data is crucial, before payment is rendered to participating healthcare providers, EWM must receive the following documents:

- **AMA-Approved Claim Forms -** Claims will be submitted to EWM for reimbursement according to program guidelines using approved AMA Claims Forms (CMS 1500 Form/ UB-92 Form).

- **Enrollment Form** - As stated in the Client Enrollment and Eligibility Section.

- **Office Documentation Forms - (according to services rendered)**
  - Screening Visit Card
  - Breast Diagnostic Enrollment/Follow Up and Treatment Form
  - Cervical Diagnostic Enrollment/Follow up and Treatment Form

- **Radiology Reports** - Payment is not rendered to radiologists, Hospitals or Radiology Facilities until the radiology report for the service billed is received by EWM.

- **Lab Report** - Payment is not rendered to laboratories until the lab report is received by EWM.

- **Pathology Report** - Payment is not rendered to pathologist until the pathology report is received by EWM.

If you have questions regarding billing and compensation please contact the EWM Central Office at 1-800-532-2227 and ask for assistance.

If you provide services to a client who does not meet age guidelines, is over income eligibility guidelines, is a Medicaid recipient or HMO member, or if you submit for reimbursement of services not in adherence with the Screening Guidelines, EWM is not liable for payment. EWM makes the official determination of age, financial and insurance eligibility for purposes of compensation.

EWM reimburses participating healthcare providers according to the EWM Fee Schedules that follow this section. **Participating healthcare providers agree to accept these fees as payment in full. Therefore, you should not bill EWM clients for services described in the EWM Fee Schedule.** Any difference in your facility's standard rates and the EWM Fee Schedule **is not** payable by EWM and **should not** be billed to the client.

Participating healthcare providers collect no fees from enrolled clients for EWM services. Clients earning up to 100% of the federal poverty guidelines receive services at no charge. Clients earning between 101% and 225% of the federal poverty guidelines may pay a donation of $5.00 for services rendered in that year regardless of the number of exams needed. EWM sends clients a donation form. **This is not payable to the clinic.** This money goes into a cash fund and is used for direct services for other clients.

Compensation and Billing *(continued)*

EWM pays participating laboratories directly for Pap tests and biopsies. ***We do not pay clinical healthcare providers a collection fee* (CPT 99000) *nor should a collection fee be billed to the client.*** Because EWM pays the laboratory directly for their services, neither the client's insurance claim nor your facility's EWM claim should list a collection fee charge. Laboratories are responsible for filing with other third-party payers first.

EWM will reimburse for lipid panels and blood glucose to participating clinics with in house labs or participating laboratories if clinics send out lab. Affix the Red and White sticker to the lab requisition so lab will bill EWM. Clinics using electronic submission of lab requisitions indicate EWM for billing purposes. Charge for venipuncture is accepted when billing for payable services. Third-party payers should be billed first.

Anesthesia

Program policies for processing Anesthesia Claims can be found in Attachment 1 - Anesthesia Rates within the Fee for Services Schedules located in the back of this section.

Hospital Claims for Surgical Procedures

Hospital fees related to services provided during approved surgical procedures are reimbursed at the approved rate set by Nebraska Medicaid. Since Medicaid Rates are not adjusted on a set schedule, hospitals are required to submit a copy of their Medicaid Rate Letter to EWM when a new rate is assigned.

Covered services listed separately on the Fee Schedule will be paid according to the schedule; all other charges related to the approved procedure will be bundled and compensation will be at the Approved Nebraska Medicaid Rate.

Services Performed in Ambulatory Surgery Centers

The Ambulatory Surgery Center (ASC) payment does not include the professional services of the healthcare provider. These are billed separately by the healthcare provider. Healthcare Providers' services include the services of anesthesiologists administering or supervising the administration of anesthesia to ASC clients and the client's recovery from the anesthesia. The term healthcare providers' services also includes any routine pre- or postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services with the individual healthcare provider usually performs.

The healthcare provider must enter the place of service code (POS) 24 on the claim to show that the procedure was performed in an ASC. The healthcare provider is paid the rate listed with an asterisk (*) on the Fee for Service Schedule (These amounts apply when service is performed in a facility setting).

The ASC will submit their claim showing the procedure performed, and will be reimbursed the Group Rate assigned to that procedure.

Program Match

EWM is required by the program funder, the Centers for Disease Control and Prevention, to obtain $1 in matching contributions for every $3 received from the funder. Participating providers agree to accept payment of allowable cost as payment in full. However, you, as a participating provider, agree to show the full amount of the charges on the bill so that the difference can be computed as a matching contribution.

Third-Party Billing

EWM is the payer of last resort. Participating healthcare providers agree to file insurance, Medicare, and other third-party claims first. You agree to accept the rates listed on the EWM Fee Schedule **as payment in full**.

If the third-party payment is greater than or equal to the maximum allowable cost described in the EWM Fee Schedule, that amount must be considered payment in full. **Do not bill EWM or the client for the services.**

If the third-party payment is less than the maximum allowable costs described in the EWM Fee Schedule, the claim should be sent to EWM, along with a copy of the explanation of benefits from the third-party payer. **Do not bill the client for these services.**

Remittance Advices (Billing Authorization)

After EWM has reviewed the claims received and processed your account, a Billing Authorization is generated. The payment document is then entered into NIS, the State's accounting system, and an invoice # is assigned to the payment document, and a copy is mailed to your facility, indicating the services authorized for payment. Once the payment document has been approved by accounting, payment will be issued, either by check or by Electronic Fund Transfer, depending on the system your facility has chosen for payment with the State Treasurer's office. **PLEASE NOTE:** the Billing Authorization is mailed separately from the payment. If you receive a paper check, the check stub will include the invoice number which was assigned to the payment document. If you are unable to identify the correct payment document, please complete the Payment Status Form (Forms & Materials Section on Page 11-11) and fax it to (402) 471-0913.

If you billed EWM for services and have not received payment, the Remittance Advice also lists any missing documentation which is delaying payment. **Please respond to only the newest Remittance Advice you have, as it shows all current missing documentation.** It is redundant to retrieve the missing reports from any Remittance Advice other than the most current one. Please keep in mind that it takes approximately two (2) weeks for the Remittance Advice to circulate from the EWM program through the State's accounting system - making the Remittance Advice two (2) weeks old by the time you receive it. We acknowledge receipt of missing documentation when payment is authorized from our office the following month.

If you provide services to a client who does not meet age guidelines, is over income eligibility guidelines, is a Medicaid recipient or HMO member, or submit for reimbursement services not in accordance with the Screening Guidelines, EWM is not liable for payment. EWM makes the official determination of age, financial and insurance eligibility for purposes of compensation.

Office Visits

EWM reimburses participating healthcare providers for an office visits using CPT codes listed in the Fee for Service Schedules that follow this section when breast or cervical cancer screening or appropriate consultation occurs at that office visit; and for cardiovascular disease and diabetes screening.

Following are situations when office visits are reimbursed:

- screening visits in which a pelvic exam in conjunction with a Pap test, clinical breast exam and breast self-exam instruction were performed, a mammogram was ordered and screening for cardiovascular disease and diabetes, if indicated, according to program guidelines
- follow up visits at which a pelvic exam in conjunction with a Pap test for cervical dysplasia and its precursors or clinical breast exam was performed or a mammogram was ordered, if indicated, according to program guidelines
- consultation for abnormal breast or cervical cancer screening result (one visit per result)
- consultation for abnormal breast or cervical cancer diagnosis (one visit per result)
- screening or follow up visit as described above at which time it is also decided to perform a diagnostic service which EWM reimburses
- second opinions related to breast and cervical cancer diagnosis

Office visits are **not reimbursed** during the following situations:

- purpose of the visit and/or procedures performed are not related to breast and cervical cancer, cardiovascular or diabetes screening
- cardiovascular and diabetes initial screening not done in conjunction with breast and cervical screening visit
- office visit for a pelvic exam alone
- visits scheduled specifically to perform a diagnostic service

If an EWM client has a scheduled office visit for breast and cervical cancer screening or appropriate consultation and it is decided during the visit to perform a diagnostic service that day, it is appropriate to bill EWM for both an office visit and a procedure code. However, if the scheduled appointment is for a diagnostic procedure, EWM should be billed only for the diagnostic procedure.

Reasonable Effort

The law authorizing the National Breast and Cervical Cancer Early Detection Program states that payment for any item or service cannot be made through this program when payment has been made or can reasonably be expected to be made under other Federal or State programs, insurance policies or by a health maintenance organization (HMO).

Therefore, EWM must make a reasonable effort to make certain that no other State or Federal program, insurance policy or prepaid health program (health maintenance organization) would make any full or partial payment for the services.

Our reasonable efforts include, but are not limited to:

- Asking for a Remittance Advice of Explanation of Benefits to accompany the claim if a client indicates that she has insurance or Medicare on her enrollment form (**NOTE:** Clients with Medicare A & B are not eligible for EWM services).
- Returning claims if the client indicates she participates in the Medicaid program.
- Asking clients to update their health insurance status every year.

If a clinic or hospital resubmits the claim stating that there is no other third party payor, for example, the client's circumstances have changed since she completed the enrollment form, EWM will accept this and process the claim. We do not require participating healthcare providers or ourselves to verify the insurance status.

DEFAULT SETTINGS for Facility vs. Non-Facility Codes

Beginning with FY 2007-2008 Billing and Compensation Tables, there are FEE differential for services provided within a Facility Setting. For the purpose of the EWM Program, "Facility" includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

The EWM Billing System has set "Default Settings" for each of the pay codes that list a different amount for procedures being provided in a Facility Setting.

The Default Settings are as follows:

1. Office Visit Codes	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99386, 99387, 99395, 99396, 99397	Non-Facility Rate; the rate without an asterisk (*)
2. Cervical Procedure Codes	57452, 57454, 57455, 57456, 57505	Non-Facility Rate; the rate without an asterisk (*)
3. Breast Procedure Codes	10021, 10022, 19000, 19001, 19100, 19101, 19102, 19103, 19120, 19125, 19290, 19291, 19295	Facility Rate; the rate WITH an asterisk (*)
4. Pathology Consultation during Surgery	88329	Non-Facility Rate; the rate without an asterisk (*)
5. Cervical Procedure Codes allowable only in accordance of program policies or requiring prior approval by Program Director.	57460, 57461, 57500, 57520, 57522, 58100	Non-Facility Rate; the rate without an asterisk (*)

The default setting for 'Facility' vs. 'Non-Facility' was based on program experience as to the most common location for the described procedure to be performed. In some cases, the procedure may take place in the opposite location as the default described; in these cases, the clinician will be compensated at the appropriate rate. ***If you are submitting claims for services opposite the default setting described in the table above, your claim should clearly show the facility in which the service was provided so compensation can be made at the appropriate rate.***

If your clinical setting is such that breast procedures, cervical procedures, or colon cancer screening procedures shown in lines 3, and 6 in the table above can/will be performed within your facility, please contact the EWM Program so your billing file can be flagged as a provider who may perform these procedures within your clinical setting. In addition, claims submitted for these services performed within your clinic setting should be clearly identified so reimbursement can be authorized at the appropriate rate.